Karl Andriessen
Karolina Krysinska
Onja T. Grad
(Editors)

Postvention in Action

The International Handbook of Suicide Bereavement Support

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Postvention in Action

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Dedication

This book is dedicated to Dr. Norman L. Farberow (1918–2015).

Foreword

It is an honor and a pleasure to have been invited by such a distinguished group of researchers and clinicians to contribute a Foreword to this important publication.

In the mid-20th century, there were usually only veiled references to suicide, let alone any suggestion that those who were bereaved through suicide should be considered worthy of study or indeed support. Furthermore, any references were usually in stigmatizing terms, as in many countries, suicide was considered not only a legal offence, but a sin against one's religion.

How this has changed has been quite remarkable, something that is comprehensively documented in this timely overview. It is timely in at least two ways: It's publication is on the 50th anniversary of Edwin Shneidman's having coined the term *postvention* in 1967; and there is now a considerable body of research that has been undertaken in the ensuing years, research which has benefitted from the introspective scrutiny which characterizes this volume.

The editors of this volume have each been leading figures in this research for several decades, and have gathered together all of the contemporary significant contributors to the field. There is no doubt that the early influential pioneers in this field, who are no longer with us, would be delighted with the result. This would particularly be the case with Norman Farberow, to whom this book is dedicated.

I have been privileged to have had a working life that has encompassed these changes. As a new graduate in the late 1960s, I was unprepared for the realities of the emergency room, where suicide attempts were increasingly prevalent, and where those who had died by suicide were brought for certification of death. These were also usually accompanied by distraught relatives or friends in both scenarios.

Pursuing the literature at that time was easy, notwithstanding the absence of computer retrieval assistance, as there had been so little written. It quickly became evident that Norman Farberow and Edwin Shneidman of the Los Angeles Suicide Prevention Center were leaders in the nascent field of suicide prevention, and they were not ignoring those who were bereaved by suicide.

I am delighted to say that I was one of a steady stream of young researchers, not the least of whom was Onja Grad, one of the editors of this work, who travelled to Los Angeles and sat at the feet of those early pioneers. Furthermore, because of the longevity of both Norman Farberow and Edwin Shneidman, both Karl Andriessen and Karolina Krysinska have also had the privilege of contact with them, thereby providing a unique editorial experience in being able to document this important area of clinical practice.

The book is divided into four logical sections: current knowledge and implications for support, suicide bereavement support in different settings, suicide bereavement support in different populations, and help for the bereaved by suicide in different countries.

In the first part, a useful introduction, which clarifies the concepts and definitions to be used and which sets the scene for the book, is followed by chapters delineating current demographic and clinical issues which are to be pursued.

The second part offers a succinct historical overview of survivor support, and then a range of different settings is described. These include family practitioner and peer counseling, and the role of religion and spirituality is not forgotten, as commonly occurs. As one would anticipate in the 21st century, the place of online suicide bereavement supports is also explored. More traditionally, but until relatively recently often overlooked, the importance of supporting families through the forensic and coronial process is addressed, a process which is almost always a harrowing experience for all involved.

The third part contains fewer chapters than the others, but each is of critical importance. The impact of cluster suicides and murder–suicide should not be underestimated; the lack of trust in the health care system is of major concern; the effect on health professionals can be a determinant of whether or not one continues in clinical work; and a description of healing practices in First Nation peoples in Canada is a good illustration of a challenge facing many other countries as well.

The final part provides a synopsis of the services for those bereaved by suicide in over 20 different countries. Not unexpectedly, most are situated in the United States and Europe. It could be argued that the number may not reflect the work that is undoubtedly being conducted in a number of other countries, as organizations such as the International Association for Suicide Prevention have many more member countries whose representatives would be familiar with the need for such services, even if they have not been formalized.

This book will be valuable as a reference for researchers and as a practical guide for clinicians who practice in this challenging but rewarding area. Much has changed in the last 50 years, and we are indebted to the editors for collating such a comprehensive overview of this previously ignored area.

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Past-President of the International Association for Suicide Prevention

Preface

Postvention

Every year, more than 800,000 people die by suicide; that is one suicide every 40 seconds (World Health Organization [WHO], 2014). Though suicide is an individual act, it happens within a sociocultural environment and a relational context. Hence, feelings of abandonment, rejection, and being a part of the "decision" for suicide are frequent among the bereaved by suicide. The bereaved may face a long and painful process of acknowledging and expressing their feelings of shock, guilt, shame, anger, and/or relief. They often struggle with thoughts, doubts, and agonizing questions related to "why this has happened," and "if I had done – or not done – this or that, *it* would not have happened." The bereaved cope with the loss, sometimes on their own, sometimes with the help of family or friends. Some turn to support groups or seek advice or therapy from professionals. Given that suicide bereavement is a risk factor for adverse mental health outcomes and suicidal behavior, there is a need for adequate suicide bereavement support.

Fifty years ago Edwin Shneidman coined the term *postvention,* referring to the support for those left behind after a suicide (Shneidman, 1969). At that time, suicidology was a young discipline, and there was neither support for the bereaved nor postvention research. Currently, postvention integrates a dual aim of facilitating recovery after suicide, and preventing adverse health outcomes among the bereaved (Andriessen, 2009). Suicide bereavement support has become available in many countries and has been recognized by the WHO (2014) as an important strategy for suicide prevention. The WHO stipulates that communities can provide support to those bereaved by suicide (WHO, 2014, p. 9), that interventions should be offered to grieving individuals (WHO, 2014, p. 37), and national suicide prevention objectives should include support for the bereaved by suicide (WHO, 2014, p. 54). It suffices to say that the evolutions of the past few decades have been truly impressive. Importantly, in many countries, survivor support has been initiated by the bereaved themselves, and clinicians and researchers have followed. In many countries, still, those bereaved by suicide are actively involved in suicide bereavement support, as well as in suicide prevention activities and research. Indeed, the days are over when postvention was looked upon as the poor counterpart of prevention: This handbook evidences the global research and clinical interest in survivor support. Postvention has become an integral and indispensable part of any comprehensive suicide prevention program. Suicidology and suicide prevention without the active involvement of survivors would be poor suicidology. Postvention is prevention. Postvention is action.

Postvention in Action

Experiences with suicide loss, working with people bereaved by suicide, involvement in postvention research and development of support programs have inspired the three editors of this handbook. It has been written for clinicians and researchers, as well as for support group facilitators and survivors involved in community activities. 94 experts from all over the world have contributed to this book. The authors have generously shared their knowledge, experience, and insights into implications for the practice of suicide survivor support. The editors of the handbook and many contributing authors are members of the International Association for Suicide

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Prevention (IASP), and specifically of the IASP Special Interest Group (SIG) on Suicide Bereavement and Postvention, which has become a major platform for the exchange of research and clinical expertise related to suicide bereavement support. Interestingly, the awareness of suicide bereavement support within the IASP has been raised due to the advocacy of dedicated survivors–researchers and survivors–clinicians, especially in the 1990s, which resulted in the first plenary presentations on postvention at IASP world congresses, and the establishment by Professor Norman L. Farberow of a Taskforce on Postvention in 1999, the taskforce being the forerunner of the current SIG.

This handbook aims to present a comprehensive overview of the state of the art of postvention, and demonstrates the evidence and practice base of suicide survivor support. All chapters are based on thorough reviews of the literature and/or original research of the authors. The book is organized into four parts. Part I is an in-depth and comprehensive presentation of current knowledge of suicide bereavement. This includes a discussion of concepts and definitions, and the age- and gender-related effects of suicide loss, especially in adults and adolescents. The following chapters focus on the grief process and on how the bereaved deal with the loss. These chapters, illustrated with vignettes, will be highly informative for clinicians, and present novel insights regarding posttraumatic growth after suicide loss, trajectories of dealing with feelings of responsibility and guilt, challenges regarding meaning making, and the process of reintegration after experiencing a suicide.

Starting with a scholarly overview of the history of survivor support, Part II of the handbook discusses suicide bereavement support in a variety of settings, including underresearched areas that may be more challenging or may require special attention regarding provision of services and support. Chapters in this part have been written by clinicians and/or researchers with ample practical experience. These chapters present a review of the effectiveness of support groups (the best-known format of survivor support), and differences in priorities of support groups between countries (Japan and the United States). Other chapters explore the suitability and pitfalls of peer counseling, and provide insights regarding the roles that general practitioners may have in survivor support. Other chapters address how bereaved families can be supported through the forensic and coronial services, discuss how workplaces may provide survivor support, and examine the roles of religion and spirituality in suicide bereavement support. Part II concludes with an overview of the fast-growing field of online suicide bereavement support, and a presentation of how personal experiences and artistic expressions can be used for the benefit of those bereaved by suicide.

Part III focuses on suicide bereavement support in specific populations. While cluster-suicide and murder–suicide events may be rare, their traumatic aftermath warrants dedicated aftercare. Suicide-bereaved parents may be in need of survivor support; however, they may have lost trust in the health care system. Health professionals who have lost a client by suicide also have to deal with the impact of the loss, and may do so in a variety of ways. Little is known about the Indigenous peoples' experience with a suicide loss, and the elders of Ojibway First Nation have shared their knowledge of healing practices involving family and the community, and the important roles of rituals and spirituality.

Part IV presents an overview of postvention practice and research in no less than 23 countries. Besides chapters covering the "usual suspects" such as the United States and western European countries, this part includes chapters presenting postvention in South America, the Asia-Pacific, and Africa. Obviously a wide variety of suicide survivor support has been developed and implemented across the world. Many countries included in this part of the handbook report on the availability of support groups; however, it is also clear that support groups may have a variety of formats and goals. For example, authors from Uruguay and Thailand report on the availability of therapeutic, professionally led groups, whereas in other countries peer-led

groups are also available. Other countries, such as Denmark and France, report wide availability of individual psychotherapy. Most of the survivor organizations are volunteer-based or involve a collaboration of professionals and peers (e.g., Canada and Italy). Typically, these organizations provide one point of access, such as a helpline, involve counselors, who may provide assessment, and offer individual or group support. Sometimes the face-to-face support is extended to online support (e.g., in Brazil), or to community awareness-raising activities, such as a national survivor day or a "walk out of darkness. Alternatively, survivor support may also be professionally based – for example, through a forensic department or coroner's office (e.g., in Australia and Hong Kong).

Support may be targeted at specific groups in society. Several countries report activities specifically for children and adolescents through support groups (Belgium), youth camps (Norway and Slovenia), or interventions at schools (Portugal). Postvention support in workplaces has become available through community organizations (Canada and the United States) or occupational health services (France), as well as support for health care professionals (e.g., from peers, supervisors, or through training; in Austria, Portugal, Slovenia, Thailand, and the United States). Some countries have developed specific support for the aftermath of suicides on the railways (e.g., Austria, The Netherlands, and the United Kingdom), and several countries offer postvention training and resources, such as websites (Australia, Slovenia, etc). Importantly, a number of countries (Ireland, the United States) have integrated postvention in national suicide postvention standards, which certainly is one way to go.

Action

It is the first time that such a vast overview of country reports has been compiled, demonstrating how postvention has become a worldwide strategy for suicide prevention. Nevertheless, this attempt at an overview also reveals serious gaps in the knowledge and practice of postvention. While there is a reasonable representation of the North American and European region, far fewer chapters could be solicited from Asia-Pacific and South American countries, and especially from Africa. Given that the majority of suicides occur outside the Westernized world, this poses challenges to the global understanding of suicide grief and mourning.

The book is dedicated to the ones we have lost through suicide, and their friends, families, and clinicians. More, the handbook is dedicated to the memory of Professor Norman L. Farberow (1918–2015), a founding father of the International Association for Suicide Prevention, who died on September 10, 2015, the World Suicide Prevention Day. Professor Farberow was a pioneer of postvention, a mentor, and a friend, and he will be remembered for his inspiring lifelong commitment to suicide prevention and postvention. It is hoped that this handbook will be a landmark resource for researchers, clinicians, and all those involved in survivor support. It is a testimony of how far and strongly the field has evolved, and it is hoped that the book may inspire further discussions and exchanges of expertise, which is essential to ensure the ongoing progress of postvention.

Postvention in action!

Karl Andriessen
Karolina Krysinska
Onja T. Grad
March 2017

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Part I

Current Knowledge and Implications for Support

Chapter 1

Current Understandings of Suicide Bereavement

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Abstract: Suicide may have a lasting impact on those bereaved by the death – that is, the survivors. They may embark on a long journey of acknowledging and expressing their grief, either alone or with the help of family, friends, support groups, and clinicians. Over the years, suicide survivor support and research – in other words, postvention – has been increasing, and the World Health Organization has identified postvention as an important suicide prevention strategy. However, major challenges remain to be solved. To further develop the field and to facilitate communication, there is a need for clarity regarding (1) concepts and definitions, (2) how many people are bereaved through suicide, and (3) whether bereavement after suicide is different and/or similar compared with bereavement after other causes of death. In addition, over the decades, several grief models have been formulated, and this chapter highlights the major models that may help to understand the grief process after loss by suicide.

Introduction

Suicide ends the pain of one but brings new pain to those left behind. For centuries, the impact of suicide on bereaved individuals and families has been ignored. The act of suicide was condemned, and often the bereaved were blamed for having a family member die by suicide (Farberow, 2003). Shneidman (1972, p. xi) referred to the tragedies that continue after the self-destructive act as "the illegacy of suicide." Only lately, since the 1960s, have the bereaved through suicide – that is, the survivors – received clinical and research attention. Contrary to past beliefs, it is now clear that those affected by suicide may face a long and painful process of acknowledging and expressing their emotions, thoughts, and behaviors to be able to move on with their lives (Grad & Andriessen, 2016). Those bereaved by suicide are at increased risk of suicidal behavior, either as a result of a bio-psycho-social vulnerability or because of identification with the person who has died by suicide (see Chapter 2 in this volume). Kinship, gender (see Chapter 4), psychological closeness, time since loss, personal and family history of mental health problems, and preloss life events, such as interpersonal loss and separations, may affect the impact of the suicide death among adults (see Chapter 2), as well as bereaved adolescents (see Chapter 3).

Over the last 50 years, the postvention field has evolved enormously (see Chapter 9 in this volume). Firstly peer, and subsequently clinical support and research activity emerged, and national survivor organizations were created. The International Association for Suicide Prevention (IASP) stressed the importance of survivor support by the establishment in 2011 of the Special Interest Group (SIG) on Suicide Bereavement and Postvention, the SIG being the for-

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mal continuation of the IASP Taskforce on Postvention initiated by Norman Farberow in 1999 (https://www.iasp.info/postvention.php). Currently, support for people bereaved through suicide is recognized as an important strategy for suicide prevention (World Health Organization [WHO], 2014). According to the WHO (2014), "intervention efforts for individuals bereaved or affected by suicide are implemented in order to support the grieving process and reduce the possibility of imitative suicidal behaviour" (p. 37), and "to be effective, national suicide prevention objectives could be designed to: … support individuals bereaved by suicide" (p. 54). As such, any discussion of suicide, a serious public health problem claiming globally more than 800,000 deaths per year, will be incomplete without taking into consideration the perspective of the bereaved.

Although the availability of, and research into, survivor support have increased, this chapter will discuss ongoing challenges in relation to postvention research, clinical practice, and the development of bereavement programs and policies. There is an increasing awareness that to further develop postvention and to facilitate communication from the local to the global level, certain issues have to be clarified (Andriessen & Krysinska, 2012; Jordan & McIntosh, 2011). There are challenges related to terminology and definitions, the number of people bereaved through suicide, and the question of if and how bereavement after suicide is different and/or similar compared with bereavement after other causes of death. In addition, over the decades, several general grief models, which also help to understand the grief process after loss by suicide, have been formulated, and these will be presented in this chapter.

Concepts and Definition

A discussion about terminology and definitions may seem very technical, academic, and distant from the daily practice of supporting the bereaved. However, the primary aim of clarity in the usage of words and definitions is to facilitate communication between people involved in the field. The development of consensus definitions would require an international project in itself, and is beyond the scope of this chapter. However, it seems useful to start with a brief presentation of concepts and definitions related to postvention.

In general, the lack of consensus about terminology related to suicide survivor support can be understood in the context of its origin and history. The first suicide survivor support groups were created in the 1970s in the United States, followed by support initiatives in other countries and continents (see Chapter 9). These initiatives were often driven by the bereaved themselves, and building on the experiences of these local initiatives, national organizations were established. However, due to the grassroots (i.e., local) origins and bottom-up evolution of suicide bereavement support, consensus definitions of routinely used key concepts have never been developed.

Although the need to formulate consensus terminologies and definitions in the field of suicide bereavement has been noted before (Jordan & McIntosh, 2011), the previous attempts to formulate consensus definitions and nomenclature in suicidology have overlooked postvention (Silverman, 2016). There is a rising awareness of the necessity of dialogue and consensus finding, and a shared nomenclature – that is, a comprehensive set of mutually exclusive terms could improve communication within the field of suicidology and in the general community (Silverman, 2016). By addressing the definitions of the major concepts related to suicide bereavement, this chapter aims to contribute to a shared nomenclature in postvention, and invites researchers, clinicians, and bereaved people worldwide to join this endeavor.

Postvention

The term *postvention* was coined and originally broadly defined by Shneidman (1969, pp. 19 & 22) as "the helpful activities which occur … after a stressful or dangerous situation … after a suicidal event." Shneidman specified that "postvention aims primarily at mollifying the psychological sequelae of a suicidal death in the survivor-victim" (Shneidman, 1969). Currently, *postvention* refers to dealing with the aftermath of suicide, with a dual focus on bereavement support and suicide prevention among the bereaved. Postvention consists of "the activities developed by, with, or for suicide survivors, in order to facilitate recovery after suicide, and to prevent adverse outcomes including suicidal behavior" (Andriessen, 2009, p. 43). Postvention involves peer and social support, clinical work, advocacy, community action, research, and policy development related to suicide bereavement.

Survivor

There are many different words for describing a person who has lost someone through suicide, such as *survivor, suicide survivor, survivor of suicide, survivor after suicide, suicide loss survivor, survivor of suicide loss, bereaved by suicide,* and *bereaved through suicide.* Words such as *survivor* have different meanings in different countries and contexts. For example, a survey among 293 people who receive the newsletter *Surviving Suicide* of the American Association of Suicidology showed that among 19 options mentioned by the respondents, more than half (58 %) endorsed *suicide survivor* as their preferred term (Honeycutt & Praetorius, 2016). However, in the equally Anglo-Saxon environment of Australia, the term *suicide survivor* is hardly used because of the confusion with suicide attempts, and the term *bereaved by suicide* is better understood (see, e.g., the *Information and Support Pack for Those Bereaved by Suicide or Other Sudden Death,* developed under the national Living Is for Everyone framework: http://livingisforeveryone.com.au/Information--Support-pack-for-those-bereaved-by-suicide-or-other-sudden-death.html).

While the term *survivor* commonly refers to those bereaved by suicide, it can mean both "to continue to live after the death of another" and "to remain alive, live on" [after an event] (Simpson & Weiner, 1989, Vol. 17, p. 313). Rather than surviving a suicide attempt, in postvention, *survivor* refers to the behavior of someone else, the subsequent death and absence of that person, and the impact on the remaining persons (Farberow, personal communication, 2007). The term *suicide attempt survivor,* recently introduced by the American Association of Suicidology in 2014, acknowledges those who have engaged in nonfatal suicidal behavior, while at the same time, makes a distinction with *suicide loss survivors* or *survivors of suicide loss* (http://www.suicidology.org).

Taking into account Farberow's principles, Andriessen (2009, p. 43) defined a survivor as "a person who has lost a significant other (or a loved one) by suicide, and whose life is changed because of the loss." Jordan and McIntosh (2011, p. 7) defined a survivor as "someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person." While acknowledging efforts to formulate these definitions, Berman (2011) noted inherent difficulties with the inclusion of the life-changing aspect in the first definition, and the high level of distress over a length of time in the second definition.

As implied by these definitions, being exposed to a suicide is not a sufficient condition to become a survivor. However, bystanders, witnesses, or acquaintances can be deeply affected by a suicide, with survivorship being predominantly a self-identified status (Andriessen, 2009). Psychological closeness appears to be a key concept in the identification as a survivor (Cerel,

McIntosh, Neimeyer, Maple, & Marshall, 2014). The formulation of a continuum of survivorship according to the magnitude of the impact of the loss (Cerel et al., 2014) may be an important approach to include the variations in survivor status inherent in the definitions. The model of Cerel et al. (2014) distinguishes four subgroups based on the level of impact: (1) those exposed to suicide without being personally affected; (2) those affected by a suicide; and those closest to the deceased who may experience grief reactions either on (3) a short-term or (4) a long-term basis. Research is needed to further specify how the different levels can be delineated and what risk or protective factors are involved.

Bereavement, Grief, Mourning

The terms *bereavement, grief,* and *mourning* are sometimes used interchangeably, whereas they do have different meanings. The word *bereaved* is defined as "deprived or robbed," and especially as "deprived by death of a near relative, or of one connected by some endearing tie" (Simpson & Weiner, 1989, Vol. 2, p. 123). Thus, *bereavement* refers to "the fact of the loss" (Zisook & Shear, 2009) and is understood, in both the dictionary and the clinical literature, as the objective status of having lost someone significant (Stroebe, Hansson, Schut, & Stroebe, 2008; Stroebe, Hansson, Stroebe, & Schut, 2001).

Grief is defined as "hardship, suffering," "mental pain, distress, or sorrow" (Simpson & Weiner, 1989, Vol. 6, pp. 834–835). In the clinical and research literature, this is understood as the "primarily emotional (affective) reaction to the loss of a loved one through death. It is a normal, natural reaction to loss" (Stroebe et al., 2008, p. 5). It incorporates diverse psychological (emotional, cognitive), physical, and behavioral responses to the death (Stroebe et al., 2001; Zisook & Shear, 2009).

Mourning is defined as "the action of mourn" and "the feeling or the expression of sorrow for the death of a person." It is "the conventional or ceremonial manifestation of sorrow for the death of a person" (Simpson & Weiner, 1989, Vol. 10, pp. 19–20). Consequently, in the clinical and research literature, mourning is understood as the public display of grief, the social expressions of grief that are shaped by the (often) religious beliefs and practices of a given society or cultural group (Stroebe et al., 2008, 2001; Zisook & Shear, 2009). Stroebe et al. (2008, 2001) emphasized the sociocultural nature of mourning. Grief expressions – for example, crying in public – that are acceptable or expected in one society may be unacceptable in other societies. Understanding grief reactions necessitates understanding the context in which the loss occurred. Given the fact that suicide bereavement has been studied almost exclusively in Western and Anglo-Saxon countries (Andriessen, 2014), while the majority of suicides occur in other parts of the world (WHO, 2014), the global understanding of suicide grief and mourning might still be in its infancy.

Complicated Grief

Whereas grief is understood as a normal, purposeful reaction to a loss, many words are currently in use to refer to an "abnormal" grief, such as *traumatic, pathological, chronic, prolonged,* or *persistent complex grief.* Most of these words are routinely used without definition, but they refer to a grief that is different from the clinical or sociocultural norm with regards to the time course, intensity, or symptoms of the grief (Stroebe, Schut, & van den Bout, 2013; Stroebe et al., 2008). They entail a state of chronic debilitating mourning, with persistent and disruptive yearning, pining, and longing for the deceased – with, for example, expressions of separation anxiety and trauma (Stroebe et al., 2013; Zisook & Shear, 2009). Suicide loss can be a risk factor for complicated or prolonged grief, and it is estimated that 7–10 % of grievers fall into this category (Kersting, Brähler, Glaesmer, & Wagner, 2011).

Most of these concepts have been developed by researchers, and are based on diagnostic criteria (Prigerson et al., 2009; Stroebe et al., 2013). However, the diagnostic criteria for these concepts often overlap. In addition, there is an overlap with diagnostic criteria for mental disorders, such as anxiety disorders, depression, posttraumatic stress disorder, and substance abuse (Stroebe et al., 2013).

Two issues warrant attention when trying to define complicated grief. Firstly, as mentioned above, cultural variation in grief expressions might challenge the understanding of "deviant" mourning. Secondly, there is a discussion in the literature over whether medicalization of grief and providing a label to a subgroup of grievers would either facilitate treatment for those in need, or increase stigmatization and treatment thresholds (Stroebe et al., 2013). A cultural and/or economic perspective might help to shed light on this discussion: A diagnosis might facilitate treatment in one country – for example, through health insurance reimbursement – but might deter people from seeking help in other countries.

Lived Experience

The expression *lived experience*[1] is used in a variety of fields related to social and health issues, mostly without a definition. In mental health, it refers to people living with mental illness (i.e., consumers or users) and their family and friends (i.e., carers) (South Australia Health, 2016). Definitions related to suicidology are almost nonexistent. Suicide Prevention Australia has described lived experience as "having experienced suicidal thoughts, survived a suicide attempt, cared for someone who has attempted suicide, been bereaved by suicide, or been touched by suicide in another way" (Suicide Prevention Australia, 2016). As such, it appears to be an umbrella term for all suicide-related experiences, including suicidal ideation, nonfatal and fatal suicidal behavior, either from one's own experience, or as a relative or carer. While this description has the potential of appealing to as many people as possible, its inherent broad character limits its usability for research purposes, and for application in postvention. In fact, the double meaning of *survivor* (referring to a suicide loss vs. a suicide attempt) may further obfuscate the understanding of lived experience, and highlights the need for conceptual clarity.

While *lived experience* is popular, it may not differ from well-established concepts such as *experiential knowledge* and *experiential expertise* (Borkman, 1976). The former term means "truth learned from personal experience with a phenomenon rather than truth acquired by discursive reasoning, observation, or reflection on information provided by others" (Borkman, 1976, p. 446), whereas the latter is defined as "competence or skill in handling or resolving a problem through the use of one's own experience" (Borkman, 1976, p. 447).

How Many People Are Bereaved Through Suicide?

The question of how many people are bereaved by suicide, and potentially in need of support, is particularly important for service planning and delivery. Shneidman (1969, p. 22) originally estimated that on average a "half-dozen" survivors are left behind after a suicide. While this educated guess of six survivors per suicide has been perpetuated in the literature, other authors have

1 The concept of *lived experience* is derived from the German *Erlebnis*, which includes the word *Leben*, *life* or *to live*. The verb *erleben* literally means *living through something*; the English term *experience* does not include the meaning of *lived* (van Manen, 2004). The current broad and undefined usage of *lived experience* risks considering everyone with a certain experience as an "expert," whereas the active and intentional process of appropriating meaning and transforming a given (passive) experience into an expertise that transcends the particular experience (Husserl, 1970; van Manen, 2004) is neglected.

estimated higher numbers: for example, Wrobleski (2002) mentions 10 survivors per suicide. A survey by Berman (2011) among members of the Survivor Division of the American Association of Suicidology found that the estimated numbers of survivors varied depending on kinship and age: Parents bereaved by child suicide estimated that there were 80 survivors ("deeply affected"; Berman, 2011, p. 111), partners and spouses estimated the number of survivors as 60, and siblings and friends indicated between 45 and 50 survivors. For all respondents, Berman (2011) estimated an average of five immediate family members bereaved by a single suicide. Also, studies based on population registers have calculated the number of survivors per suicide for selected types of relationship. Kuramoto et al. (2010) and Wilcox et al. (2010) found that on average two children are bereaved after the suicide of a parent. Botha et al. (2009) and Chen et al. (2009) estimated an average of four to five relatives bereaved by a suicide in the family.

Findings regarding the variety of relationships of people being exposed to a suicide have fueled the ambiguity regarding the numbers of survivors. Campbell (1997) described 28 different types of relationship among individuals seeking suicide bereavement support from the Crisis Intervention Center in Baton Rouge, Louisiana, USA. The majority consisted of nuclear family members (80 %); other relatives, friends, and acquaintances accounted for the remaining 20 %. A telephone survey in the United States found 27 different relationships among individuals who knew someone who had died by suicide (Cerel, Maple, Aldrich, & van de Venne, 2013). In this study, friends were the largest relationship category (35 %), and nuclear family members accounted for 7.5 % of the group. In addition, while the reported exposure to suicide is higher among certain populations, such as clinicians, prisoners, and military veterans, it has been noted that the social networks of those dying by suicide are smaller than those of people with natural deaths (Stack, 2007). Those dying by suicide are more likely to be divorced, living alone, less frequent churchgoers, and more socially isolated. On the other hand, younger suicides may have more living relatives (Stack, 2007).

To better comprehend the diversity of numbers cited in the literature, Andriessen, Rahman, Draper, Dudley, and Mitchell (2017), conducted a meta-analysis of 18 population-based studies, which reported rates of past-year and lifetime prevalence of people who had experienced a suicide among family or friends, or had personally known someone who had died through suicide. The meta-analysis found that pooled lifetime prevalence of exposure to suicide was higher than past-year prevalence (21.8 % and 4.3 %, respectively). Past-year prevalence of suicide in the family (1.1 %) was significantly lower than exposure to suicide among friends and peers (5.6 %), and in all relationships (6.3 %). There were no statistically significant differences regarding past-year prevalence of exposure to suicide by age group – that is, adolescents versus adults.

Similar to the past-year prevalence, lifetime prevalence of suicide in the family (3.9 %) was significantly lower than exposure to suicide in friends and peers (14.5 %), and in all relationships (29.4 %). Life-time exposure to suicide by age group and type of relationship revealed a mixed picture. Among adults exposure to suicide in the family (3.9 %) was lower than exposure to suicide in all relationships (36 %) while there were no differences among adolescents.

Further analysis found that both past-year and lifetime prevalence of exposure to suicide in the family was approximately 8 to 5 times lower respectively, than prevalence of exposure in all relationships after controlling for country and age group of exposure. Given that the impact of suicide might be stronger when experienced at a younger age (see Chapter 3 in this volume), studies are needed to further investigate suicide exposure, impact of the loss, and support needs among adolescents, with regard to types of relationship and psychological closeness to the deceased.

Is Suicide Bereavement Different From Other Bereavement?

There appear to be contradictions in the answers to the question of whether suicide bereavement is different from bereavement experienced after other causes of death, usually depending on who is answering the question. Personal accounts of the bereaved, including published autobiographies (e.g., Fine, 1999), and narratives of clinicians seem to stress the uniqueness of the experience of suicide survivors. The recurrent themes in the narratives of survivors include guilt, shame, social stigma, search for meaning, and suicidal ideation. Research findings, especially from controlled studies, indicate that there are more similarities than differences between different groups of the bereaved, regarding major grief themes, the grief process, its duration and outcomes (Bolton et al., 2013; Sveen & Walby, 2008).

The model developed by Jordan and McIntosh (2011, p. 34) might be helpful to accommodate the contradictory perspectives of survivors, clinicians, and researchers (**Figure 1.1**). The model consists of four concentric circles. The outside circle represents features of bereavement that may be found independent of the cause of death: sorrow, pain, missing, and yearning to be reunited with the deceased. The second circle includes features typical for bereavement after unexpected deaths, such as shock and a sense of unreality. The third circle includes features of bereavement after violent deaths, such as the experience of trauma, and the shattered illusion

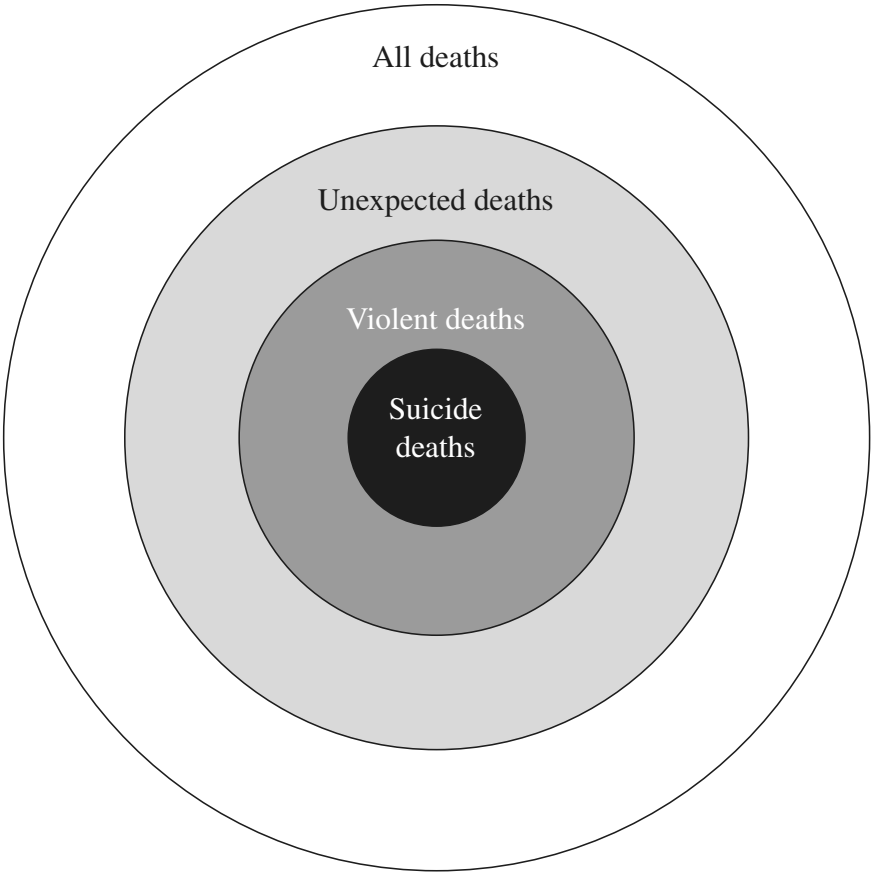

Figure 1.1 Aspects of bereavement related to the mode of death. Republished with permission of Routledge, from Jordan & McIntosh, 2011, p. 34; permission conveyed through Copyright Clearance Center, Inc.

of personal invulnerability. Finally, the fourth and inner circle includes features typically associated with bereavement after suicide. These include anger at the deceased, aggression, and feelings of abandonment and rejection (Jordan & McIntosh, 2011).

Some grief features seem to be more pronounced, though not unique, in suicide bereavement. The feeling of *guilt* is one of the most common feelings experienced by suicide survivors (see also Chapter 6). The reasons for this feeling may differ for each individual, but they include the feeling of not having been able to recognize the possible suicide warning signs or not having been able to prevent the death. Guilt may be fueled by the feeling that not enough attention was given to earlier suicide attempts, depressive behavior, or the effects of mental disorders on the deceased. Special circumstances, such as not living together (e.g., parents of adult children), may also trigger guilt. Guilt may stem from the feeling of relief – for example, when the suicide ended suffering associated with a chronic mental or physical illness, or when family members or caregivers became fatigued and hoped that the suffering would stop. Overestimating one's own responsibility and ability to stop the suicidal process, and thoughts and fears of having directly contributed to the death – for example, because of marital separation, a threat to leave, or a quarrel prior to the suicide – may also result in feelings of guilt (Grad & Andriessen, 2016). Sometimes the bereaved start to worry that another family member may become suicidal. Additional care and attention may be directed toward a family member who retains the same lifestyle as before the suicide, which seems dangerous, such as engaging in life-threatening sports or substance/alcohol abuse (Grad, 2011).

Another common theme is *searching for reasons* for the person's decision to end their life. This process may happen even if the suicidal person had more or less clearly talked about the suicide. It may be difficult to accept that someone close has not communicated their thoughts and problems, has neither asked for help nor shown any recognizable signs of risk. Many bereaved meticulously investigate their own behavior and the behavior of the deceased to find internal (psychological or biological) and/or external explanations for the suicide. It is important for the suicide survivors to know whether the suicide was a personal, willful decision or an act that was driven by particular problems, mental illness or other difficult circumstances (Grad, 2011).

This process of searching for reasons may result in *blaming and anger* toward oneself and/or others. Blame and anger are very difficult and painful to admit, and even more difficult to express openly (Grad, 2011; Tekavčič Grad & Zavasnik, 1992). The most painful is self-blame fueled by guilt. Blaming others can be directed at members of the close and extended family, colleagues, friends, schoolmates, teachers, and superiors at work. Professionals who took care of the person who died, such as doctors, therapists, and nurses, are also often blamed for the suicide. Moreover, blame and anger can be directed at the deceased for letting the survivor down or leaving them alone with their problems.

Many survivors report changed behavior within their social network. They may feel that they are being looked down upon or overlooked by others, and they may interpret this in the context of the taboo associated with suicide. It is unclear to what extend these feelings result from the survivors' projection of feelings of guilt and shame onto others, and to what extent these are real reactions of others (Feigelman, Gorman, & Jordan, 2009; Grad, 2011). Lower self-esteem, embedded in the social stigma of suicide, brings particular challenges to caregivers as they attempt to help suicide survivors. The self-stigmatizing process of survivors often makes it difficult to accept social support even though it is offered. Furthermore, suicide survivors often report that people in their social network do not know how to react *(social ineptitude)* (Dyregrov, 2003). As a result, some people prefer to ignore the fact of suicide or to withdraw from the survivor's social circle. Conversely, the bereaved may feel that they are "being silenced"

by others, or they might silence themselves, and refrain from talking about their bereavement (Maple, Edwards, Plummer, & Minichiello, 2010).

Grief Models and Suicide Bereavement

Though no grief models have been developed specifically or solely to describe grief after suicide (let aside if that would be desirable), general grief models may provide useful frameworks and concepts to understand suicide bereavement. This section presents a snapshot overview of models relevant to grief after suicide. A comprehensive overview of the development of theories of grief in general can be found elsewhere (e.g., Stroebe, Hansson, Schut, & Stroebe, 2008).

While the literature on grief and mourning can be traced back over centuries (Burton, 1621/2001; Darwin, 1872/2009), the works of Freud (1917/1957) and Lindemann (1944) have been instrumental in shaping contemporary Western views on grief. Freud (1917/1957) distinguished grief (which he called "mourning") from melancholia, and based on clinical observations, he found that grief may lead to depression. Freud introduced the notion of *grief work (Trauerarbeit)* emphasizing the intrapersonal nature of the grief process, which should result in detachment of the lost object. Lindemann (1944) shaped the notion of "acute" grief, and the characteristics of what he considered to be "normal" grief reactions, such as preoccupation with the deceased and feelings of guilt, versus unhealthy, for example, delayed grief or absence of grief reactions. As such, the literature of the first half of the 20th century laid a foundation for current views that grief is a normal reaction to a major loss. However, those early views already acknowledged that grief may result in adverse health outcomes, including psychiatric problems.

The course of grief was first initially studied and described as a series of stages (e.g., Bowlby, 1980). According to the stage models, the grief process starts with an initial stage of shock, denial, and numbness, followed by intermediate stages of yearning and protest, and disorganization and despair, and results in adjustment and acceptance of the loss. Revisiting Freud's (1917) notion of grief work, Worden (1991) shifted the focus from the consecutive grief stages to the *how* of grieving. Worden postulated that a grieving person faces four tasks: accepting the reality of the loss, experiencing the pain of the loss, adjustment to an environment without the deceased person, and relocating the deceased emotionally to embark on a new life. The stage models tend to view the grief process as a temporary phase in life, which usually ends in acceptance of the loss (detachment from the deceased), and recovery after having worked through (or having resolved) the loss (Rothaupt & Becker, 2007; Wortman & Silver, 2001). According to the literature on complicated or *prolonged grief disorder,* prolonged grief should be diagnosed after 6 months (Prigerson et al., 2009). Yet, no research has found a common endpoint in terms of resolution, detachment, or recovery of normal grief, which varies in duration from short-lived grief reactions to longer-term or delayed reactions, which may occur even a few years after the loss (Bonanno, Boerner, & Wortman, 2008; Wortman & Silver, 2001). Obviously, the stage models are not helpful for understanding the bereaved person if they are interpreted in a rigid, prescriptive way regarding how people should process their loss, rather than as a description of what might occur.

Research of recent decades has broadened the perspective and helped to overcome some of the limitations inherent to (interpretations of) the earlier models (Rothaupt & Becker, 2007). The perspective on grief has shifted from stage thinking to a more humanistic approach to how individuals deal with the loss, taking into consideration the sociocultural aspects of grieving, and possible positive outcomes of the grief process. For example, in line with the task of emotional relocation of Worden (1991), Klass, Silverman, and Nickman (1996) found that

the majority of bereaved individuals stay connected with the deceased. Contrary to being a pathological factor, as postulated by stage models, the continuing bond, sometimes expressed through rituals, may be a potential source of support for the bereaved.

Stroebe and Schut (2010) transformed the grief work model by complementing its loss-oriented approach with a dynamic interaction: The bereaved individual oscillates between loss-oriented (e.g., dealing with rumination) and restoration-oriented stressors (e.g., taking up a new role). Because of the interplay between past, present, and future, this dual process model helps to better understand how the bereaved can make meaning of the loss, and provides insight into the occurrence of delayed grief reactions and anniversary reactions (Stroebe & Schut, 2001). Balk (2004) noted that recovery in terms of restoring the lost world is impossible; however, the bereaved person may redefine or reintegrate their life (see also Chapter 8 in this volume).

According to a social constructionist perspective, people understand their grief not merely by intrapsychic grief work, but primarily through interactions taking place within their social and cultural environment (Neimeyer, Klass, & Dennis, 2014). Following the loss of the assumptive world and the challenges posed to cognitive coping (Grad, 2005), the bereaved person engages in a process of narrating and interpreting the life and death of the deceased person and the loss experience, and ascribes meaning to what has happened. The grief experience is not limited to the factual situation, but consists of its interpretation and the meaning it has for the bereaved person. There seems to be an association between the inability to make sense of the loss and the impact of violent bereavement after a death through suicide, homicide, or accident on symptoms of complicated grief among the bereaved (Currier, Holland, & Neimeyer, 2006).

Suicide bereavement research and support may well benefit from recent insights of research into general grief concepts. Holland and Neimeyer (2010) conducted a study of stage theory of grief among adults bereaved by natural and violent causes of death, including suicide. They found that characteristics of grief related to specific stages waxed and waned. Meaning making appeared to be a much stronger predictor of grief characteristics than time since loss, except for those bereaved by violent deaths, where both time since loss and meaning making appeared to be important. Neimeyer and Sands (Chapter 7 in this volume) present an account of how meaning reconstruction may be achieved after loss by suicide; and Genest, Moore, and Nowicke (Chapter 5 in this volume) investigated posttraumatic growth among those bereaved by suicide, resulting in positive outcomes regarding self-perception, interpersonal relationships, and life philosophy.

Implications for Practice

A considerable number of people in the general community are exposed to suicide (Andriessen et al., 2016). For example, in a school with 500 students, or in a company with 500 employees, there are on average 20 individuals who have experienced a suicide of a family member or a friend during the last year. Given the fact that suicide loss is a risk factor for adverse health outcomes, including mental health and suicidal behavior (Chapter 2 in this volume), it is of utmost importance to provide for service planning and to secure resources for suicide bereavement support.

Despite the common feelings and reactions experienced by many bereaved irrespective of the cause of death, the individual grief process after a suicide is as unique as a fingerprint (Clark & Goldney, 2000, p. 470). This may pose challenges to clinicians and support group facilitators who work with survivors after suicide. As Bonanno et al. (2008) pointed out, views